**MDR Tracking Number: M5-04-2736-01**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-26-04.

The IRO reviewed office visits, office visits with manipulation, hot/cold pack therapy, electric stimulation therapy, myofascial release, ultrasound therapy and electrodes rendered from 05-20-03 through 07-10-03 that were denied based on "V" and "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 06-21-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR$ | Reference | Rationale |
|---|---|---|---|---|---|---|---|
| 05-28-03 06-25-03 | 99080-73 | $40.00 (1 unit @ $20.00 X 2 DOS) | $0.00 | V | $15.00 | Rule 133.106(f) | Services were denied with denial code V. These are TWCC required reports and therefore are reviewed as fee issues. The requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $15.00 X 2 = $30.00 |
| TOTAL | | $40.00 | $0.00 | | | | Requestor is entitled to reimbursement in the amount of $30.00 |

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 05-28-03 and 06-25-03 in this dispute.

This Findings and Decision and Order are hereby issued this 2nd day of August 2004.

Debra L. Hewitt
Medical Dispute Resolution
Medical Review Division

DLH/dlh


# Envoy Medical Systems, LP
**1726 Cricket Hollow**
**Austin, Texas 78758**

**Ph. 512/248-9020** **Fax 512/491-5145**
**IRO Certificate #4599**


**NOTICE OF INDEPENDENT REVIEW DECISION**

July 22, 2004

**Re: IRO Case # M5-04-2736** amended 7/26/04

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 2/27/03 – 7/8/03
2. Explanation of benefits
3. Review 5/9/03
4. Office notes from treating D.C
5. D.C. treatment notes.
6. D.C. reports 3/28/03, 2/4/03
7. TWCC work status reports
8. Assessment of duty related injury 1/20/03
9. Initial report 1/20/03
10. D.O. reports
11. Electrodiagnostic study report 4/15/03
12. Counseling evaluation and treatment plan 3/28/03
13. Referral forms 3/20/03
14. Radiology reports sacroiliac joints, lumbar spine 1/21/03
15. PPE report 1/23/03

History

The patient injured his lower back in ___ when he climbed into a fire truck. He sought chiropractic care on 1/20/03. An MRI of the lumbar spine was obtained. He has been treated with chiropractic treatment, TPIs, medication and physical therapy.

Requested Service(s)

Office visit, office visits with manipulation, hot/cold pack therapy, electric stimulation therapy, myofascial release, ultrasound, electrodes 5/20/03 – 7/10/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient was initially diagnosed with a sprain/strain injury of the left sacroiliac joint. This type of injury should have resolved with appropriate treatment in six to eight weeks.

Yet the D.C. was still treating the patient six months later.

A 2/5/03 MRI showed a left hemisacralization of L5 and degenerative disk disease at the L4-5 level with posterior disk bulge. TPIs and chiropractic treatment provided little lasting relief. Passive modalities failed to be beneficial, which is common with degenerative disk disease.

Based on the records provided, the patient will have recurring problems with his back with frequent flare ups because of the arthritis in his low back. The sprain/strain should have resolved after a couple of months of treatment, well before the dates in dispute. The treatment in dispute was excessive. Chronic and ongoing treatment with poor response does not establish a medical rationale for further non-effective treatment.

Based on the records provided, an active form of rehabilitation might be appropriate for this patient.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____